Hawaii Employer-Union Health Benefits Trust Fund
CONFIRMATION NOTICE - Open Enrollment

Print Date: 05/22/2003

DOE, John
1234 Honolulu Street
Honolulu, HI 96000

Employee ID: HB00000
Date of Birth:
Agency/Dept: State ERS Retirees
Event Date: 07/01/2003

Please review your Benefit Plan enrollments and other information on this confirmation notice. If you find any errors, please make the necessary corrections, sign and date the form and mail it to the Hawaii Employer-Union Health Benefits Trust Fund, P.O. Box 2121, Honolulu, HI 96805 within 2 weeks of the above Print Date.

If there are no corrections, keep this form with your important family records.

YOUR BENEFIT PLAN ENROLLMENTS

Benefit Plan	Benefit Plan Carrier	Coverage Type	Effective Date
Medical/Drug	Kaiser Foundation Health Plan	Employee Only	07/01/2003
Dental	Hawaii Dental Service	Employee Only	07/01/2003
Vision	Vision Service Plan	Employee Only	07/01/2003
Life	Aetna Inc.		07/01/2003

Please make the above corrections to my Benefit Plan Open Enrollment information.

Signature: _____ **Date:** __/__/____